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In hospital, at home, or not at all

A cross-sectional survey of patient preferences for receipt of compulsory treatment

AIMS AND METHOD

In view of plans to reform Mental Health Act legislation to allow compulsory treatment in the community, we examined the views of service users about this form of care, and the most acceptable setting for its delivery. A cross-sectional survey of patients discharged from two in-patient units in West London over a 5-month period was carried out.

RESULTS

Half of the 109 respondents stated that compulsory treatment was justified under some circumstances; 103 people told us where they would prefer to receive compulsory treatment – 49 in their home, 41 in hospital and 13 in a community treatment centre. The most commonly stated reason for favouring home treatment was dislike of in-patient care.

CLINICAL IMPLICATIONS

Compulsory treatment in the community may provide a means of improving patient experiences of non-consensual care. However, a significant minority of service users would rather this form of treatment was restricted to in-patient units. Continuing efforts are required to improve patient experiences of in-patient care.

Debate about the potential value of compulsory community treatment has been made more urgent over recent years by proposals to reform the Mental Health Act 1983 in England and Wales. Compulsory community treatment has been promoted as a means of delivering non-consensual treatment in a less restrictive environment (Department of Health, 1999). Others have argued that it may lead to increased use of coercion, and damage the relationship between service users and providers (Moncrieff & Smyth, 1999).

Psychiatrists appear divided about the potential value of compulsory community treatment. A survey of over 1000 consultant psychiatrists in England and Wales found that 46% favoured compulsory treatment in the community, 34% opposed it and 19% were undecided (Crawford et al, 2000). More recently, a survey of 415 mental health professionals reported that 62% of psychiatrists, 36% of mental health social workers and 28% of community psychiatric nurses supported plans for compulsory community treatment (Pinfold et al, 2002). However, little is known about the views of users of mental health services. A survey of both users and carers belonging to the mental health charity National Schizophrenia Fellowship (1999) reported that 58% were in favour of compulsory treatment in the community. These findings contradict those in a report from the voluntary organisation Mind, which provided anecdotal evidence of users' concerns about the possible impact of compulsory community treatment (Mind, 2004).

Patients belonging to such groups may be unrepresentative of service users in general, and may include those with no experience of in-patient or compulsory treatment. We therefore set out to examine the attitudes to compulsory treatment among patients with recent experience of in-patient psychiatric care. We aimed to estimate the proportion who believe that compulsory treatment may be justified, the preferences of service users for where it should be delivered, and to explore reasons for these preferences.

Method

We conducted a cross-sectional survey among patients discharged from one of two mental health units in West London over a 5-month period. We obtained the names of potential participants through electronic and paper records, and attempted to contact all those aged over 18 years and resident in Greater London. Patients were excluded if they had a primary diagnosis of dementia, insufficient English to complete the questionnaire or if they did not provide informed consent.

We used a short questionnaire designed specifically for the study, consisting of a series of open and closed questions about compulsory treatment in different settings. It included a measure of satisfaction with care, the Quality of Care Questionnaire (Shiple et al, 2000), and questions on insight based on those used by David (1990). A draft version of the questionnaire was piloted

**Table 1. Demographic and clinical characteristics of the study sample (n=171)**

Characteristic	Responders (n=109)	Non-responders (n=62)	Difference in proportions/means	P
Age, years: mean (s.d.)	41.1 (15.4)	43.0 (14.6)	1.9 years	0.44
Gender (n (%))				
Male	64 (58.7)	24 (38.7)	20%	0.01
Female	45 (41.3)	38 (61.3)		
Marital status (n=142): n (%)				
Married/cohabiting	17 (18.3)	5 (10.2)	8%	0.21
Unmarried	76 (81.7)	44 (89.8)		
Ethnicity (n=152): n (%)				
White	54 (56.3)	35 (62.5)	6%	0.22
Black	25 (26.0)	8 (14.3)		
Other	17 (17.7)	13 (23.2)		
Diagnosis (n=145): n (%)				
Psychosis	74 (74.0)	35 (77.8)	4%	0.63
Neurosis	11 (11.0)	4 (8.9)		
Alcohol/drug misuse	7 (7.0)	2 (4.4)		
Personality disorder	8 (8.0)	4 (8.9)		
Admission status (n=170): n (%)				
Voluntary	67 (61.5)	46 (75.4)	14%	0.07
Compulsory	42 (38.5)	15 (24.6)		
Satisfaction score (n=107): mean (s.d.) ¹	5.5 (3.3)			
Insight (n=107): n (%)				
Moderate/good	45 (42.1)			
Poor	62 (57.9)			

1. Assessed using the Quality of Care Questionnaire.

among recently discharged patients attending a local day hospital. At an early stage in this process we discovered that patients were often unsure what was meant by the phrase 'compulsory treatment'. Having tried alternatives, we settled on asking their views about having to 'take medication against their will', a phrase that people understood without need for further clarification. The final version of the questionnaire took approximately 10 min to complete and was administered either by telephone or in person by someone independent of clinical services. Patients were contacted through their keyworkers within 8 weeks of discharge from hospital. Local research ethics committee approval was obtained prior to the start of data collection.

Interview data were entered into the Statistical Package for the Social Sciences (version 11.0) for statistical analysis. Data on satisfaction were not normally distributed and were therefore converted to a categorical variable to aid data analysis (see Table 3). Data on insight were used to create a binary variable, with patients categorised as having poor insight if they stated that they did not have a mental illness or if their keyworker told us that they often or never accepted treatment. Odds ratios for belief that compulsory treatment cannot be justified and preference for receipt of compulsory treatment in the patient's own home were calculated with 95% confidence intervals. Binary logistic regression was used to examine the combined effect of different explanatory variables, using a forward step-wise approach.

Responses to open-ended questions were sorted using a draft coding frame developed after a preliminary examination of patient responses. A grounded approach

was used to further analyse and categorise these data (Glaser & Strauss, 1967).

Results

Two hundred and eighteen patients were discharged from hospital over the 5-month period, of whom 171 were eligible to participate. Of the 47 ineligible patients, 28 (60%) lived outside Greater London, 10 (21%) had a primary diagnosis of dementia, 5 (11%) were unable to communicate in English sufficiently to complete the study questionnaire and 4 (9%) were deceased. One hundred and nine people (64% of eligible patients) completed the study. Of the remainder, 35 (56%) refused to take part and the remaining 27 (44%) could not be traced. Characteristics of responders and non-responders are presented in Table 1. Women and those who had been treated on a voluntary basis proved more difficult to trace and were less likely to complete the survey.

Responses to questions about compulsory treatment are presented in Table 2. The characteristics of the 52 patients who responded that compulsory treatment might be justified are compared with the 41 who responded that it was never justified are set out in Table 3. Multivariate analysis indicated that two variables were associated with the belief that it is not right to make a person take medication against their will; dissatisfaction with care (OR 10.2, 95% CI 2.15–38.8) and poor insight (OR 9.63, 95% CI 2.50–36.90). Although having insight was strongly associated with the belief that compulsory treatment may be justified, 12 (29%) of the 41 judged to have good insight believed that it was not

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papers**Table 2. Attitudes of 106 patients to compulsory treatment in different settings**

Statement	Agree n (%)	Disagree n (%)	Don't know n (%)
Do you think that it is ever right to make a person take medication against their will?	52 (49.1)	41 (38.7)	13 (12.3)
Do you think that if someone needs to take medication against their will, they should be admitted to hospital before this can happen? ¹	39 (39.4)	23 (23.2)	37 (37.4)
Do you think that if someone needs to take medication against their will, it should be possible for this to happen when they are in their home, without admitting them to hospital? ²	24 (24.0)	26 (26.0)	50 (50.0)

1. Answered by 99 participants.
2. Answered by 100 participants.

right to force someone to take medication against their will.

When asked where they would prefer to receive future compulsory treatment, 49 of the 103 respondents

Table 3. Factors associated with belief that compulsory treatment is unjustified and preference for delivery of compulsory treatment within one's own home

Characteristic	Belief that compulsory treatment is never justified (n=93) OR (95% CI)	Preference for compulsory treatment in own home (n=103) OR (95% CI)
Age, years		
< 30	1.00	1.00
30–45	0.49 (0.17–1.41)	1.25 (0.44–3.56)
> 45	0.40 (0.13–1.24)	1.67 (0.67–4.78)
Gender		
Male	1.00	1.00
Female	1.82 (0.79–4.19)	2.09 (0.94–4.66)
Marital status		
Unmarried	1.00	1.00
Married/cohabiting	0.44 (0.13–1.54)	0.44 (0.14–1.40)
Ethnicity		
White	1.00	1.00
Black	2.74 (0.94–3.80)	1.22 (0.46–3.22)
Other	2.10 (0.64–6.74)	1.07 (0.34–3.38)
Diagnosis		
Non-psychotic	1.00	1.00
Psychotic	1.76 (0.73–4.27)	2.17 (0.94–4.98)
Admission status		
Voluntary	1.00	1.00
Compulsory	2.36 (1.01–5.53)*	0.92 (0.42–2.03)
Mean satisfaction score		
Satisfied (0–4)	1.00	1.00
Fairly satisfied (5–8)	1.33 (0.45–4.00)	1.04 (0.36–3.01)
Dissatisfied (9–12)	3.85 (1.36–10.75)*	1.64 (0.46–3.34)
Insight		
Moderate/good	1.00	1.00
Poor	2.94 (1.23–7.02)*	1.03 (0.47–2.25)

*P < 0.05.

to this question (48%) told us they would prefer to be treated in their home, with 41 (40%) preferring hospital and 13 (13%) preferring treatment in a community centre. Characteristics of patients who stated that they would prefer treatment in their own home are presented in Table 3. Multivariate analysis showed that women were more likely to prefer being treated in their own home than men (OR 3.17, 95% CI 1.17–8.64). Eighty-seven patients provided a reason for their preference for where compulsory treatment should be delivered. The most frequently stated reasons for preferring home treatment were dislike of hospitals (37%), familiarity with the home environment (25%), upheaval associated with being admitted to or discharged from hospital (20%) and the belief that home treatment offered greater freedom and independence (18%). Patients preferring compulsory treatment at home told us:

"People in hospital are frightening."
"Anywhere but in hospital. . . there is not enough space, it's like a prison."
"You have quietness at home and your own things around."
"You can get more of a grasp of a person's problems if they are in their own home."

Those preferring treatment in hospital stated that the reasons for this were the more intensive level of support available in hospitals (53%), the feeling that the home is a private place that services should not enter (29%) and a lack of support available from family and other informal carers (18%). Among comments from patients who preferred compulsory treatment in hospital were:

"You can talk to staff in hospital. . . I needed to be watched and encouraged."
"I feel safe at home. . . people shouldn't be intimidated in their own home."
"I need to be away from my family as they find it upsetting when I am ill."

Discussion

Patients have a broad range of attitudes towards the use of compulsory treatment. Although half of those interviewed believed that it may be right to force someone to take medication against their will, many others were opposed to or uncertain whether this practice is ever justifiable. When asked where they would prefer to



receive compulsory treatment, 60% responded that they would prefer it to be delivered without the need for admission to hospital. The most commonly stated reason for wanting home treatment was a dislike of in-patient hospital care. This finding mirrors that of a US study in San Francisco, where compulsory community treatment is already practised (Swartz *et al*, 2003).

Concerns have previously been expressed that the focus on community services and the reduction in the number of in-patient beds have led to higher levels of disturbance and lower standards of care on psychiatric in-patient units (Griffiths, 2002). Previous surveys of people receiving psychiatric in-patient treatment report that many feel unsafe and up to a quarter experience verbal or physical aggression (Greenwood *et al*, 1999). Patients told us that they would prefer to receive compulsory treatment in their home in order to avoid the tense and sometimes hostile atmosphere of in-patient units. This observation emphasises the importance of current efforts to improve the quality of in-patient psychiatric care.

We found that women were more likely than men to favour compulsory treatment at home. Although we were able to obtain responses from almost two-thirds of our sample, the original sample was not large and it is possible that a bigger sample would have permitted identification of other characteristics associated with preference for home treatment – notably a trend towards this preference among older patients and those with a diagnosis of a psychosis. Details of plans for compulsory treatment in the community are yet to be decided, but are likely to include the delivery of interventions other than psychotropic medication. Although we did not examine patient attitudes towards these other aspects of compulsory treatment, we feel that focusing on medication enabled us to obtain patient views about salient aspects of compulsory care in general.

Our finding that only a quarter of patients were in favour of changing the law to allow home treatment may seem to contradict another of our findings, that a greater number of patients would prefer to receive compulsory treatment in their home rather than in hospital. This may reflect the ambivalence that many patients have towards any form of compulsory treatment. Patients may prefer the idea of receiving compulsory treatment in their home, but are likely to be opposed to changes in legislation if these result in increased use of compulsory treatment (Mind, 2004).

Compulsory treatment in the community may offer an opportunity to deliver non-consensual treatment to patients in a more acceptable form. However, it is

important to note that a significant minority of patients will continue to seek and need in-patient treatment. Changes to enable compulsory treatment at home should not take place at the expense of ongoing efforts to improve users' experiences of in-patient care.

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Declaration of interest

None.

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